**Patient Satisfaction Survey**



Dear Patient: According to our records, you recently visited **Cary Plastic Surgery.** Please tell us your opinion about the service you received **from this provider**. Your responses will be kept strictly confidential. Thanks for your help.



**PLEASE RATE THE FOLLOWING:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  | Very |  |  |  | Does Not |
| **A. YOUR APPOINTMENT:** |  |  | Excellent | Good | Good | Fair | Poor | Apply |
|  |  |  |  |  |  |  |  |  |
| 1. | Ease of making appointments by phone |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. | Appointment available within a reasonable amount of time | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. | Getting care for illness/injury as soon as you wanted it | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. | Getting after-hours care when you needed it |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 5. | The efficiency of the check-in process |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 6. | Waiting time in the reception area |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 7. | Waiting time in the exam room |  |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 8. | Keeping you informed if your appointment time was delayed | 5 | 4 | 3 | 2 | 1 | N/A |
| 9. | Ease of getting a referral when you needed one | 5 | 4 | 3 | 2 | 1 | N/A |
| **B. OUR STAFF:** |  |  |  |  |  |  |  |  |  |  |
| 1. | The courtesy of the person who took your call |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. | The friendliness and courtesy of the receptionist | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. | The caring concern of our nurses/medical assistants | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. | The helpfulness of the people who assisted you with | 5 | 4 | 3 | 2 | 1 | N/A |
|  |  | billing or insurance |  |  |  |  |  |  |  |  |  |
| 5. | The professionalism of our lab or x-ray staff |  | 5 | 4 | 3 | 2 | 1 | N/A |
| **C. OUR COMMUNICATION WITH YOU:** |  |  |  |  |  |  |  |  |
| 1. | Your phone calls answered promptly |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. | Getting advice or help when needed during office hours | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. | Explanation of your procedure (if applicable) |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. | Your test results reported in a reasonable amount of time | 5 | 4 | 3 | 2 | 1 | N/A |
| 5. | Effectiveness of our health information materials | 5 | 4 | 3 | 2 | 1 | N/A |
| 6. | Our ability to return your calls in a timely manner | 5 | 4 | 3 | 2 | 1 | N/A |
| 7. | Your ability to contact us after hours |  | 5 | 4 | 3 | 2 | 1 | N/A |
| 8. | Your ability to obtain prescription refills by phone | 5 | 4 | 3 | 2 | 1 | N/A |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | Very |  |  |  | Does Not |
|  |  | Excellent | Good | Good | Fair | Poor | Apply |
| **D. YOUR VISIT WITH THE PROVIDER:** |  |  |  |  |  |  |
|  | **(Doctor, Physician Assistant, Nurse Practitioner)** |  |  |  |  |  |  |
| 1. | Willingness to listen carefully to you | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. | Taking time to answer your questions | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. | Amount of time spent with you | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. | Explaining things in a way you could understand | 5 | 4 | 3 | 2 | 1 | N/A |
| 5. | Instructions regarding medication/follow-up care | 5 | 4 | 3 | 2 | 1 | N/A |
| 6. | The thoroughness of the examination | 5 | 4 | 3 | 2 | 1 | N/A |
| 7. | Advice given to you on ways to stay healthy | 5 | 4 | 3 | 2 | 1 | N/A |
| **E. OUR FACILITY:** |  |  |  |  |  |  |
| 1. | Hours of operation convenient for you | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. | Overall comfort | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. | Adequate parking | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. | Signage and directions easy to follow | 5 | 4 | 3 | 2 | 1 | N/A |
| **F. YOUR OVERALL SATISFACTION WITH:** |  |  |  |  |  |  |
| 1. | Our practice | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. | The quality of your medical care | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. | Overall rating of care from your provider or nurse | 5 | 4 | 3 | 2 | 1 | N/A |
| **WOULD YOU RECOMMEND THE PROVIDER TO OTHERS?** | Yes |  |  | No |  |  |

**IF NO, PLEASE TELL US WHY:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE TELL US ABOUT IT:**

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| --- | --- | --- | --- |
| **SOME INFORMATION ABOUT YOU:** |  |  |  |
| **GENDER** |  | **YOUR AGE** |  | **ARE YOU:** |  |
| Male | 1 | Under 18 | 1 | A new patient | 1 |
| Female | 2 | 18-30 | 2 | A returning patient | 2 |
|  |  | 31-40 | 3 |  |  |
|  |  | 41-50 | 4 |  |  |
|  |  | 51-60 | 5 |  |  |
|  |  | Over 60 | 6 |  |  |